

For CA Office Use Only

MCC: _____ EIS: _____ Access/MMIS: _____ Letter sent: _____ County: _____

**Division of Medical Assistance
Provider Services**

**1985 Umstead Drive – 2501 Mail Service Center – Raleigh, N.C. 27699-2501
919-857-4017
www.dhhs.state.nc.us/dma**

Carolina ACCESS Application for Participation- Primary Care Provider

Pages 1, 2 and 3 of this application must be completed and submitted with the Agreement containing an original signature. Report all changes to information provided in this application via the Carolina ACCESS Provider Information Change form, which is available on DMA's web site, <http://www.dhhs.state.nc.us/dma/forms.html>.

Is this application being sent to replace an existing Carolina ACCESS (CA) application/Agreement? () **Yes** () **No**

Has this practice or any participating primary care provider in this practice (listed on Page 2 of this application) been sanctioned or terminated by either the Medicaid Program or the Carolina ACCESS Program? () **Yes** () **No**

N.C. Medicaid Provider Number (**will become your CA provider number upon approval**): _____

Practice Name: _____

Street Address: _____
_____ County: _____

Mailing Address (if different from the above street address): _____

Telephone Number: (____) _____ After-Hours Phone Number: (____) _____

Fax Number: (____) _____ Email Address: _____

Identify a contact person for CA issues: Name: _____ Title: _____

Practice Specialty: _____

Is this practice a Rural Health Clinic? () **Yes** () **No** Is the practice a Health Department? () **Yes** () **No**

Is the practice a Federally Qualified Health Center? () **Yes** () **No**

Indicate the desired maximum number of CA enrollees to be enrolled with this CA provider number: _____

Note: Upper limit is 2000 enrollees per participating provider listed on Page 2 of this application.

List any specific enrollment restrictions such as age and gender: _____

Are new Medicaid patients accepted? () **Yes** () **No** Is Medicare accepted? () **Yes** () **No**

List all contiguous counties from which this practice will accept CA enrollees: _____

I am applying to participate as a primary care provider in the Carolina ACCESS program sponsored by the Department of Health and Human Services, Division of Medical Assistance.

Authorized Signature: _____ **Date:** _____

Title/Position: _____

For DMA Office Use Only

Application approved by DMA: Yes () No () Effective Date: _____

DMA Authorized Signature: _____ Date: _____

Admin Entity: _____ Date: _____ Review Date: 1) _____ 2) _____ 3) _____

**Carolina ACCESS
Application for Participation**

List all Primary Care Providers (PCPs) in this practice applying for Carolina ACCESS (CA) participation at this time using the Medicaid provider number indicated in Page 1.

Full Names of PCPs to be listed with this CA Practice	Title (e.g. MD, FNP, PA) (Required)	Licensed Specialty (Required)	License Number (Required)	Individual Medicaid Provider Number (Required for Physicians)

Which providers listed above provide inpatient hospital care at a hospital participating with the NC Medicaid Program that is within thirty (30) miles or forty-five (45) minutes drive time from the practice?

Provider's name(s):

Name and location of hospital(s):

Ages admitted:

If none of the participating PCPs included on this application provides inpatient hospital care, or if the ages of all potential Carolina ACCESS enrollees are not addressed by the "ages admitted" in the above chart, then complete the attached Carolina ACCESS Hospital Admitting Agreement form and submit the document containing the original signatures with this Application for Participation.

Carolina ACCESS
Application for Participation

List Office Hours (i.e., Mon 8 a.m.-5 p.m., Tues 9 a.m.-1 p.m., Wed 8 a.m.-5 p.m., etc.): _____

Total number of hours that a provider is available to see patients at this location: _____

Note: 30 hours per week is the minimum requirement.

Indicate after-hours coverage (check all that apply):

Note: The practice shall not refer automatically to the Emergency Department (ED), nor shall calls to the hospital switchboard be referred directly to the ED.

- ☐ Answering Service
- ☐ Answering machine that gives the number of the provider to call
- ☐ Hospital operator who pages on-call provider
- ☐ Call forward or stay-on-line transferring
- ☐ Nurse Triage Service
- ☐ Other (please describe) _____

Indicate all interpretation services available.

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Oral Interpretation Services
Note: Required for all non-English languages. | <input type="checkbox"/> TDD/TTY |
| <input type="checkbox"/> Sign Language | <input type="checkbox"/> Braille |
| <input type="checkbox"/> Other: _____ | |

Indicate all preventive and ancillary services available to patients within the practice and without referral:

Note: To qualify, samples/specimens must be collected on-site, but may be sent out for testing.

(Check all that qualify.)

- | | |
|--|---|
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Adult Preventive Annual Health Assessment Services |
| <input type="checkbox"/> Hemoglobin | <input type="checkbox"/> Cervical Cancer Screening |
| <input type="checkbox"/> Hematocrit | <input type="checkbox"/> Tetanus Vaccine (Td) |
| | |
| <input type="checkbox"/> Health Check Screening Exam | <input type="checkbox"/> Tuberculin (TB) Testing (via PPD intradermal injection/Mantoux method) |
| <input type="checkbox"/> Standardized Written Developmental Screening (e.g. Ages and Stages, PEDS) | <input type="checkbox"/> Influenza Vaccine |
| <input type="checkbox"/> Hearing Assessment (using electronic equipment, e.g. audiometer) | <input type="checkbox"/> Pneumococcal Vaccine (PCV) |
| <input type="checkbox"/> Vision Assessment (e.g., Snellen Chart) | <input type="checkbox"/> Haemophilus Influenzae Type b Vaccine (Hib) |
| <input type="checkbox"/> Blood Lead Screening | <input type="checkbox"/> Inactivated Polio Vaccine (IPV) |
| <input type="checkbox"/> Hepatitis B Vaccine | <input type="checkbox"/> Measles, Mumps, Rubella Vaccine (MMR) |
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis Vaccine (DTaP) | <input type="checkbox"/> Varicella Vaccine |

For DMA Office Use Only

DMA Authorized Signature: _____ Date: _____